



New Hampshire

Receptor Selective NSAID Medications
NH Medicaid Prior Authorization/Non-Preferred
Drug Approval Form
Fax: 1-888-603-7696 Phone: 1-866-675-7755



Date of Medication Request: \_\_\_/\_\_\_/\_\_\_

SECTION I: Patient Information and Medication Requested

Name: (Last, First) \_\_\_\_\_ NH Medicaid #: \_\_\_\_\_
Date of Birth: \_\_\_/\_\_\_/\_\_\_ Gender:  Male  Female
Drug Name: \_\_\_\_\_ Strength: \_\_\_\_\_
Dosing Directions: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

SECTION II: Clinical History

- 1. Patient's diagnosis: \_\_\_\_\_
2. Is the patient 75 years of age or older?  Yes  No
3. Does the patient have a sulfonamide allergy?  Yes  No
4. Did the patient fail two or more receptor selective NSAID medications, one being a high affinity NSAID, e.g., Lodine® (Etodolac), Feldene® (Piroxicam), Voltaren® (Diclofenac) or Dolobid® (Diflunisal)?  Yes  No
5. Was the patient intolerant of:
• one receptor selective NSAID medication?  Yes  No
If Yes, check all that apply:  Edema  GI Symptoms  Failure to control pain
• a second receptor selective NSAID medication:  Yes  No
If Yes, check all that apply:  Edema  GI Symptoms  Failure to control pain
6. Indicate which of the following apply: Previous history of a GI bleed  Yes  No Date: \_\_\_/\_\_\_/\_\_\_
Current use of oral corticosteroid  Yes  No
Peptic Ulcer Disease  Yes  No

Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.

If you are requesting a non-preferred product, proceed to Section III. If not, then proceed to Section IV.

SECTION III: Non-Preferred Drug Approval Criteria

Chapter 188 of the Laws of 2004 requires that Medicaid only cover non-preferred drugs upon a finding of medical necessity by the prescribing physician. Chapter 188 requires that you base your determination of medical necessity on the following criteria.

- Allergic reaction  Drug-to-drug interaction. Please describe reaction: \_\_\_\_\_
 Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information: \_\_\_\_\_
 Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug. Please provide clinical information: \_\_\_\_\_
 Age specific indications. Please provide patient age and explain: \_\_\_\_\_
 Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a reference: \_\_\_\_\_
 Unacceptable clinical risk associated with therapeutic change. Please explain: \_\_\_\_\_

SECTION IV: Prescriber Information

Name: \_\_\_\_\_ NPI #: \_\_\_\_\_
Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

\_\_\_\_\_

Signature of Prescribing Provider